TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, March 8, 1905.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

PYLORECTOMY FOR CARCINOMA.

DR. CHARLES L. GIBSON presented a man, fifty-three years old, who entered St. Luke's Hospital on November 28, 1904. For a number of years past he had suffered from gastric and intestinal disturbance, but his serious trouble began about a year ago. He then first complained of severe gastric pain, increased by taking food; he had frequent attacks of vomiting, and he lost flesh and strength.

An examination failed to reveal any physical signs. There was no tumor in the region of the stomach. On examination of the stomach contents, free hydrochloric acid was present, and the result rather militated against the diagnosis of carcinoma. In spite of this, an exploratory laparotomy was decided on, and a good-sized tumor involving the pylorus and lesser curvature of the stomach was found. A wide resection was done by the usual method, embracing practically one-half of the stomach, and the operation was completed by doing a posterior gastro-enterostomy.

The patient's convalescence was fairly uneventful. His temperature never went above 101° F., and he left for his home on the twenty-seventh day after the operation. His weight had increased from 116 to 145 pounds, which was the most he had ever weighed in his life. The pathological examination of the tumor proved it to be a carcinoma.

Dr. Gibson said he had showed this case to particularly emphasize the fact that in some instances of this kind an operation should be undertaken more or less tentatively, without waiting for the classical signs of carcinoma.

Dr. F. Kammerer said that in operating on cases of tumor of the stomach, it was frequently a difficult matter to decide whether to remove the pylorus or not. He recalled three cases in which the tumor at the pylorus was evidently benign, although presenting the gross appearance of cancerous growths, and was not removed. In one of these the speaker said he had occasion to reopen the abdomen seven weeks after the primary operation, and he then found that the tumor had entirely disappeared. The question that had to be decided in dealing with these cases was whether to do a resection or a simple gastro-enterostomy, or some other plastic operation on the pylorus. Pylorectomy was certainly a much more severe operation than either the Finney operation or a gastro-enterostomy.

Dr. Kammerer said that the absence of free hydrochloric acid in the stomach contents could not always be relied upon, and he agreed with Dr. Gibson that an operation was advisable, even in doubtful cases. During the past few months he had operated on five cases of benign tumor of the pylorus. In some of those cases the symptoms were indefinite, pointing to a chronic ulcer of the stomach, with pyloric stenosis. In all of them very marked changes at the pylorus were found.

Dr. Howard Lilienthal emphasized the importance of thorough and repeated examination of the stomach contents in doubtful cases. At least half a dozen examinations should be made, and these would oftentimes show surprising variations in the percentage of free hydrochloric acid, ranging from a normal quantity to its entire absence. Dr. Lilienthal thought that all doubtful cases of tumor of the stomach should be looked upon as malignant, and treated accordingly. A palliative operation done in a malignant case was a calamity if a radical operation could possibly have been done instead.

Dr. Gibson, in closing, said the surgeon was often led astray by the report of the examination of the stomach contents, and he suggested that improvement along that line of clinical investigation would be of great benefit in the diagnosis of obscure gastric lesions.

TUBERCULOSIS OF THE OLECRANON BURSA.

DR. GIBSON presented a woman, forty-three years old, who noticed a lump in the region of the olecranon fossa of the left arm about four years ago. There was no history of traumatism. The mass gradually became larger, until it extended half-way down the forearm. Upon incision, it proved to be a tuberculous process of the superficial bursa of the olecranon. It was removed without difficulty, and the patient made an uneventful recovery.

TUBERCULOSIS OF THE BREAST.

DR. GIBSON also showed a tubercular tumor of the breast which was removed under the supposition that it was an adeno-fibroma.

SUBDIAPHRAGMATIC ABSCESS.

DR. JOHN A. HARTWELL presented a woman, forty-eight years old, married, who was admitted to the Lincoln Hospital on May 19, 1903, with the history that for seven months prior to her admission she had suffered from pain in the right hypochondrium and the anterior lumbar region. Nothing more definite regarding her previous history could be elicited.

Examination showed a rather poorly nourished woman, who apparently had undergone a good deal of suffering. The thoracic viscera were normal. Abdominal examination revealed considerable tenderness in the right hypochondriac and lumbar regions, and a movable tumor just above the iliac spine which gave the characteristics of a movable kidney. The appendicular region was also tender. The patient's temperature ranged between 100° and 102.5° F.; the pulse between 100 and 120, and the respirations between 24 and 28. The pain persisted, with varying severity.

May 21, 1903, an exploratory incision was made through the middle of the right rectus, because neither the movable kidney nor the appendix seemed to account for the symptoms present. The movable tumor proved to be a kidney. There were many adhesions in the neighborhood of the gall-bladder and the transverse fissure of the liver, and a lesser number around the appendix. There were no indications, however, of a cholecystitis or an abscess in this region. The adhesions were broken up, and

the structures about the subhepatic region were freed. The appendix was then removed, and the laparotomy wound closed. The movable kidney was then anchored through a posterior incision, after the technique advocated by Edebohls. Pathologically, the appendix showed a mild grade of chronic inflammation of the mucous membrane.

The patient's symptoms were entirely relieved during the first five days following the operation, the temperature and pulse having both fallen to normal and remained so.

On the fifth day the patient's temperature again rose to 100.5° F., and this was repeated during the following two weeks, at intervals of twenty-four or forty-eight hours. In the meantime, both wounds had healed primarily. On the tenth day the temperature reached 102° F., and there developed râles over the lower right chest. The patient was gradually losing flesh and strength. A diagnosis of tuberculosis, probably pulmonary, was made, and on the twenty-sixth day after the operation she returned to her home in rather poorer condition than she was at the time of her admission.

During the three weeks that she remained at home, her irregular fever persisted, and the emaciation progressed. There was also present more or less constant pain, similar to that complained of prior to the operation. Her attending physician, Dr. Francis A. Auleta, examined her from time to time, and finally, on July 1, found signs of fluid in the right posterior chest, low down, and an exploratory puncture through the ninth intercostal space in the posterior axillary line withdrew pus.

The patient was readmitted to the hospital on July 2, 1903, and operated on the same day. An incision was made over the ninth rib, just anterior to the angle of the scapula. About an inch and a half of the rib were resected, exposing the pleura. The pleural cavity was closed by stitching the two layers together with catgut, with gauze packed around it. An incision was then made through the two pleural layers and the diaphragm, exposing the postero-superior border of the liver. The œdema and fibrous exudate in this region indicated the near presence of pus, and, by palpating the liver, fluctuation was obtained. An incision was made into the presenting surface of the liver, and a blunt instrument inserted, which resulted in a flow of thin, grayish pus. This opening was then enlarged, and almost a quart of pus evacu-

ated. The site of the abscess was not definitely determined, but it seemed to be under the liver rather than in it, the puncture apparently passing through the organ near its posterior border.

The kidney that had been operated on could be palpated through the wound, and was firmly fixed in the position in which it had been anchored.

The wound was packed and drained. Recovery was prompt and uninterrupted, the cavity filling entirely in about five weeks, when the patient was discharged. Since then she had remained in excellent health. The pleura did not become infected at any time. The case was interesting because of the unexplained cause of the abscess, and because of the apparent improvement after the first operation, which failed to locate the trouble.

CHOLECYSTECTOMY FOR GALL-STONES.

DR. HARTWELL presented a woman, twenty-six years old, who was admitted to the Lincoln Hospital on May 10, 1904, suffering from cholelithiasis, with the following history: With the exception of a mild attack of what may have been biliary colic five years ago, she had always enjoyed excellent health. She had never had any acute sickness, and her menstrual and maternal life had been absolutely normal, having had one child and no miscarriages. Her digestion and nutrition had always been good.

Five weeks prior to admission, she was suddenly seized with intense epigastric pain, which subsequently extended over the right hypochondrium. Violent vomiting, sweating, and marked prostration accompanied the pain. The latter she described as being a "tearing or crushing pain" over the lower costal arches. There was no change in the color or character of the stools or urine. The attack continued two days, and could only be controlled by anodynes. No jaundice appeared then or later. From that day to the time of her admission she had never been free from pain in the right hypochondrium, and the acute attacks occurred at frequent intervals, from a few hours to two days. There was no relation between the taking of food and the attacks of pain. Sometimes the latter would radiate to the right shoulder. No calculi were ever seen in the stools. Since the onset of her attack she had lost about twenty pounds.

On admission, the following notes were made regarding her physical condition: There was marked adiposity; no jaundice; the thoracic viscera were normal; the abdomen showed distinct tenderness and rigidity over the region of the gall-bladder for an area about four inches in diameter. On account of the abundance of fat in the abdominal wall, no distinct tumor could be felt. The patient's temperature was 102° F.; pulse, 120. The leucocyte count was 15,000. The urine had a specific gravity of 1030; it was acid in reaction, amber in color, contained a cloud of albumen and granular and hyaline casts.

Operation, May 11, 1904. The gall-bladder was found much distended, adherent, and thickened. In breaking the adhesions the bladder ruptured, and an enormous number of sand calculi, with purulent bile, were discharged into the wound. The largest was the size of a buck-shot, and the smallest less than the size of a pin-head. The ducts, on palpation, showed no stones present. The cystic duct was not ligated because it tore away from the suture and was not again found. The gall-bladder, after its removal, was widely opened, and a count showed something over 1200 calculi present, with an estimated total of about 1500. The largest was the size of a small pea.

The patient's convalescence was uninterrupted, the sinus closing in about six weeks, the free flow of bile during the first two weeks demonstrating the patency of the cystic duct.

Dr. Lilienthal said that in dealing with very large gall-bladders, he thought it safer, as a matter of technique, to empty them before extirpating them. By following this method, one would be less apt to cause rupture. As to the tearing out of a suture, the speaker said he had never seen it happen when it was passed through the walls of the cystic duct. In Dr. Hartwell's case, the duct was apparently exceptionally tender.

In reply to a question, Dr. Lilienthal said he did not consider it particularly dangerous to have the gall-bladder rupture during an operation; still, he preferred to avoid that accident, if possible. The speaker said he could easily conceive of a case in which stones of considerable size might happen to be lost in the abdominal cavity and decidedly interfere with the healing process.

RESECTION OF STOMACH FOR CARCINOMA.

Dr. Willy Meyer presented a specimen obtained from a woman, forty-eight years old, who was admitted to the German Hospital early in November, 1904. For two months previous to that time her health had been gradually declining. An examination showed that the stomach was evidently much enlarged, and, after more than thirty minutes' lavage, particles of food taken several days before were still ejected. A distinctly movable tumor could be made out, lying principally to the right of the xiphoid cartilage.

The abdomen was opened on November 10, 1904, and a tumor was found involving the pylorus and at least half of the upper portion of the duodenum, and projecting into the lumen of the stomach. There were many enlarged glands below the greater curvature. The stomach was divided between two Kocher clamps, and the cut borders wiped with lysol solution. The portion of the stomach to be resected was surrounded with gauze, and turned towards the right side of the patient. The cardial portion of the stomach was now closed in the usual way. A small duodenal clamp was then applied at the distal end of the tumor, and an intestinal compression clamp next to it, as low as possible. The latter clamp having been removed, the gut was surrounded with a silk ligature and divided above it, and its cut end provided with a purse-string suture. Before this was tied, the assistant accidentally withdrew the silk ligature from the gut, allowing some of the duodenal contents to escape. After thoroughly cleansing the wound, the cut surfaces of the gut were inverted and closed by two rows of interrupted silk. The head of the pancreas was conveniently near, and, following his usual custom in these cases, Dr. Meyer made use of it by stitching it over the line of suture. A posterior gastro-enterostomy was then done with Murphy's button, and, on account of the protruding mucous membrane, three additional interrupted silk sutures were inserted. After these had been placed, as the gut seemed to be kinked a good deal at the point of anastomosis, the efferent part was stitched to the stomach wall with a few sutures. Finally, the omentum was turned up and stitched over the pancreas and the divided duodenum. With the exception of some symptoms pointing to intestinal obstruction, which were relieved

by the passage of the button on the eighteenth day, the patient made an uneventful recovery. At present she is in perfect health.

SACCULATED POPLITEAL ANEURISM; MATAS'S OPERATION.

Dr. Willy Meyer reported a case of Matas's operation for popliteal aneurism, with remarks upon the procedure.

BILATERAL CERVICAL RIB; CONGENITAL TORTICOLLIS; SPINAL CURVATURE AND MENINGOCELE.

Dr. Royal Whitman presented a boy, ten years of age, with a cervical rib on each side, associated with extreme congenital torticollis, spinal curvature, and a meningocele on the back of the head. The torticollis had been improved by a division of the muscles a year ago, and, although a facial atrophy was extreme, the improvement was marked. The most significant sign of cervical ribs was broadening of the base of the neck and the abnormal resistance to labial pressure in this region.

DISLOCATION OF THE SHOULDER-JOINT.

Dr. Whitman presented a girl, eight years old, who probably, as the result of injury at birth, sustained a dislocation at the right shoulder, with accompanying obstetrical paralysis. When Dr. Whitman first saw her last August, the arm was turned inward, the forearm was pronated, and function was very poor. The luxation of the humerus was reduced, and the child now has good use of the arm. With proper and regular exercises, Dr. Whitman said, perfect function of the limb should be restored.

THE TREATMENT OF CONGENITAL AND ACQUIRED LUXATIONS AT THE SHOULDER IN CHILDHOOD.

Dr. Royal Whitman read a paper with the above title, for which see page 110.